Section 7 Third-Party Insurance

Medicaid Payment Guidelines for Third-Party Coverage

Federal regulations require Medicaid to be the "payer of last resort." This means that all third-party insurance carriers, including Medicare and private health insurance carriers, must pay before Medicaid processes the claim. Additionally, providers must report any such payments from third parties on claims filed for Medicaid payment.

If the Medicaid-allowed amount is more than the third-party payment, Medicaid will pay the difference up to the Medicaid-allowed amount. If the insurance payment is more than the Medicaid-allowed amount, Medicaid will not pay any additional amount.

Certain Medicaid programs are not considered "primary payers" regarding the payer-of-last-resort provision. When a Medicaid recipient is entitled to one or more of the following programs or services, Medicaid pays first:

- Vocational Rehabilitation Services
- Division of Services for the Blind
- Division of Public Health "Purchase of Care" Programs
  - Cancer program
  - Prenatal program
  - Sickle Cell program
  - Children's Special Health Services
  - Kidney program
  - School health fund
  - Tuberculosis program
  - Maternal and Child Health Delivery funds

Services Provided to Medicare-Eligible Medicaid Recipients

Medicaid denies claims for recipients aged 65 and older who are entitled to Medicare benefits but do not apply for Medicare. The provider may bill the recipient for Medicare-covered services under these circumstances.

Capitated Payments

Providers who accept capitated payments from private plans and bill Medicaid for any balance must bill only the co-payment amount due from the recipient. Do not bill Medicaid the full charges, even with the capitated amount indicated as an insurance payment. Medicaid is not responsible for any amount in excess of the amount for which that recipient is responsible.

Discounted Fee-for-Service Payments

The Medicaid program makes payments to providers on behalf of recipients for medical services rendered, but Medicaid is not an "insurer." Medicaid is not responsible for any amount for which the recipient is not responsible. Therefore, a provider cannot bill Medicaid for any amount greater than what the provider agreed to accept from the recipient's private plan. If the recipient is not responsible for payment, then Medicaid is not responsible for payment. The provider should bill only the amount that the provider has agreed to accept as payment in full from the private plan.

Noncompliance Denials

Medicaid does not pay for services denied by private health plans due to noncompliance with the private health plan's requirements. If the provider's service would have been covered and payable by the private plan, but some requirement of the plan was not met, Medicaid will not pay for the service.

If the recipient has a private plan and does not inform the provider of such a plan, and if the plan's requirements were not met because the provider was unaware of them, the provider may bill the recipient for those services if both the private plan and Medicaid deny payment due to noncompliance.

Similarly, if the recipient fails to cooperate in any way in meeting any private plan requirement, the provider may bill the recipient for the services. If however, the recipient does present the private payer information to the provider and that provider knows that s/he is not a participating provider in the plan or cannot meet any of the private plan's other requirements, the provider must so inform the recipient and also tell the recipient that the recipient will be responsible for payment of services.

Common noncompliance denials include failure to get a referral from a participating PCP, failure to go to a participating provider, failure to obtain a second opinion, and failure to obtain prior approval.

Third-Party Liability

Determining Third-Party Liability

The following information helps providers to determine if a Medicaid recipient has third-party liability (TPL):

1. Check the recipient's MID card for third-party insurance information. The insurance data block lists the codes for up to three health or accident insurance policies and Medicare Part A and Part B applicable to the recipient. Insurance information on the card includes
   - Insurance company name (by code)
   - Insurance policy number
   - Insurance type (by code)
   - Recipient covered by policy
2. Before rendering service, providers should ask the recipient if s/he has any additional health insurance coverage or other TPL. If health insurance is indicated, the provider must bill the carrier before billing Medicaid. Before filing a claim with Medicaid, the provider must receive either payment or a written denial from the insurance company.
3. Check the RA. When a claim is denied for other insurance coverage (EOB 94), the provider's RA will indicate the other insurance company (by code), the policy holder name, and the certificate or policy number.

If the insurance company or other third-party payer terminates coverage, providers must complete a Health Insurance Information Referral (DMA-2057) and attach a copy of the written denial. Send the form and the claim to DMA's Third Party Recovery (TPR) section at the address shown on the form.

Use the same form to report lapsed insurance coverage or insurance coverage not indicated on the MID card.

A copy of the form is available in **Appendix G-22** or on DMA's Web site at http:www.ncdhhs.gov/dma/forms.html.

Time Limit Override on Third-Party Insurance

All requests for time limit overrides due to a third-party insurance carrier that does not respond within its time limit must be submitted to the TPR section and include documentation verifying that the claim was timely filed to the third-party insurance carrier.

If the third-party insurance carrier does not respond within the Medicaid time limit, time limit overrides may be granted if the claim is filed within 180 days of the third-party denial or payment. Submit the claim attached to the Medicaid Resolution Inquiry Form and the third-party voucher.

Refunds to Medicaid

When a provider does not learn of other health insurance coverage for a recipient until after receipt of Medicaid payment, the provider must do the following:

1. File a claim with the health insurance company.
2. Upon receipt of payment, refund Medicaid the insurance payment or the Medicaid payment in full, whichever is less.
3. The provider may keep the larger payment.

Unless DMA requests in writing that refunds should be sent to another address, providers send refunds to EDS.

Refer to **Provider Refunds** on page 8-11 for additional information on refunds to Medicaid.

Personal Injury Cases

Tort (Personal Injury Liability)

Medicaid recipients may qualify for other third-party reimbursement because of an accident, illness, or disability. A third party, or other than those already cited, may be legally liable. Frequently, these injuries and illnesses result from automobile accidents or on-the-job injuries or illnesses not covered by Workers' Compensation.

N.C. General Statutes § 108A-57 allows the State subrogation rights (that is, the State has the right to recover any Medicaid payments from personal injury settlement awards).

Provider's Rights in a Personal Injury Case

When a provider learns that a Medicaid recipient has been involved in an accident, the provider **must** notify the TPR section. If the provider has knowledge of the accident at the time of filing the claim, a Third Party Recovery Accident Information Report (DMA-2043) must be submitted with the claim. A DMA-2043 must also be submitted when anyone requests a copy of the bill. A copy of the form is available in **Appendix G-23** or on DMA's Web site at http://www.ncdhhs.gov/dma/forms.html.

The following information is required by the TPR section to pursue a case, and will assist the provider when filing a claim with the liability carrier:

- Name of insurance company
- Name of insured person responsible
- Insurance policy number
- Name and address of the attorney, if any

Note: A copy of a letter sent by an attorney or insurance carrier to the provider requesting information will suffice in lieu of the DMA-2043.

Billing for Personal Injury Cases

The provider must choose between billing Medicaid and billing the liability carrier. Providers cannot initially file a casualty claim with Medicaid, receive payment, and then bill the liability carrier (or the recipient) for the same service, even if the provider refunds Medicaid.

The provider cannot bill the recipient, Medicaid, or the liability carrier for the difference between the amount Medicaid paid and the provider's full charges. (See Evanston Hospital v. Hauck, 1 F.3d 540 [7th Cir. 1993])

Providers who withhold billing Medicaid have six months from the date of a denial letter or receipt of payment from the insurance company to file with Medicaid, even if the end of the six months is after the end of the usual 365-day filing deadline.

The following requirements must be met:

- The provider must file a claim with the third-party carrier or attorney within 365 days from the date of service.
- The provider makes a bona fide and timely effort to recover reimbursement from the third party.
- The provider submits documentation of partial payment or denial with a claim to Medicaid within six months of such payment or denial.

Payment for Personal Injury Cases

When Medicaid payment is received, the provider is paid in full and there is no outstanding balance on that claim. Once Medicaid makes a payment for a service, only Medicaid has the right to seek reimbursement for payment of service.

If the provider withholds billing Medicaid and receives a liability payment, the provider may bill Medicaid with the liability payment indicated on the claim. Medicaid may pay the difference if the Medicaid-allowable amount is greater than the liability payment and the payment amount will be less than or equal to the recipient liability.

Providers may receive liability payments when they have not pursued or sought third-party reimbursement. The provider may not keep any liability payment in excess of Medicaid's payment. Pursuant to federal regulations and the Evanston case, there is a distinction between private health insurance payments and other liable third-party payments.

Refunds and Recoupments for Personal Injury Cases

If Medicaid discovers that a provider received Medicaid payment and communicated with a third-party payer or attorney in an attempt to receive payment of any balance, Medicaid will recoup its payment to that provider immediately, regardless of whether the provider ultimately receives payment from that third party.

The following is an example of how a liability payment should be treated:

Amount billed by provider to Medicaid	$100.00
Amount paid by Medicaid	$50.00
Amount paid by attorney/liability carrier	$100.00
Amount to be refunded to Medicaid	$50.00
Amount to be refunded to attorney/liability	$50.00

Third-Party Liability—Frequently Asked Questions

1. **What is TPL and how does it apply to me?**

   TPL is another individual or company who is responsible for the payment of medical services. Most commonly, these third parties are private health insurance, auto, or other liability carriers. There are state and federal laws, rules, and regulations setting out TPL requirements, which require these responsible third parties to pay for medical services before Medicaid is billed. The TPR section is responsible for implementing and enforcing these TPL laws through both cost avoidance and recovery methods. Therefore, providers who know of the existence of TPL are required to seek payment from these third parties prior to seeking payment from Medicaid.

2. **Why was my claim denied for EOB 094, "Refile indicating insurance payment or attach denial."?**

   The database indicates the recipient had third-party insurance on the date of service for which you are requesting reimbursement and that this type of insurance should cover the diagnosis submitted for payment. If your service could be covered by the type of insurance indicated, you must file a claim with that insurance company prior to billing the Medicaid program. If you receive a denial that does not indicate noncompliance with the insurance plan, or if you are paid for less than your charges, bill the Medicaid program and, if appropriate, your claim will be processed. If the Medicaid-allowable amount is greater than the insurance payment you received, Medicaid will pay the difference up to the recipient liability. It is the provider's responsibility to secure any additional information needed from the Medicaid recipient to file the claim.

   If the insurance plan denied payment due to noncompliance with the plan's requirements, Medicaid will not make any payment on the claim.

   If the insurance data was not indicated on the recipient's MID card, it was entered on the database after the MID card was printed and should be on the next MID card. You may also find this insurance information in the denial section of your RA.

   Note: This denial code does not refer to Medicare.

3. **How do I determine the name and the address of the third-party insurance company that is indicated on the recipient's MID card?**

   A list of the Third-Party Insurance Codes is available upon request from the TPR section or on DMA's Web site at http://www.ncdhhs.gov/dma/tpr.html. This code list provides the name and billing address for each code that is listed in the insurance data block on the MID card under the subheading "Name Code."

4. **How do I determine what type of insurance the recipient has?**

   Blue and pink MID cards list an insurance name, code, policy number, and insurance type code. Buff MEDICARE-AID ID cards list the insurance name code only. The insurance type codes are listed below. This is a key to be used by the providers in identifying third-party resources as shown by the code on the MID card in the insurance data block under the subheading "Type."

The codes listed below are DMA codes and have no relationship with the insurance industry.

Code	Description
00	Major medical coverage
01	Basic hospital w/surgical coverage
02	Basic hospital coverage only
03	Dental coverage only
04	Cancer coverage only
05	Accident coverage only
06	Indemnity coverage only
07	Nursing home coverage only
08	Basic Medicare supplement
10	Major medical & dental coverage
11	Major medical & nursing home coverage
12	Intensive care coverage only
13	Hospital outpatient coverage only
14	Physician coverage only
15	Heart attack coverage only
16	Prescription drugs coverage only
17	Vision care coverage only

Direct questions to the TPR section, Cost Avoidance Unit, at 919-647-8100.

5. What do I do when my claim is denied for EOB 094 and no insurance is indicated on the MID card?

Refer to the RA that showed the claim denying for EOB 094. The insurance information—including the policy holder's name, certification number, and a three-digit insurance code—are listed below the recipient's name.

A list of Third-Party Insurance Codes is available upon request from the TPR section or on DMA's Web site at http://www.ncdhhs.gov/dma/tpr.html.

6. What is considered an acceptable denial from an insurance company?

An acceptable denial is a letter or an EOB from the insurance company or group/employers on company letterhead that complies with the policy reflected in question #7. Forward claims for questionable denials to the TPR section:

Division of Medical Assistance
Third Party Recovery
2508 Mail Service Center
Raleigh NC 27699-2508

If the provider has an acceptable denial or EOB, attach the denial to the claim and forward to EDS Provider Services:

EDS
Provider Services
P.O. Box 300009
Raleigh NC 27622

7. **Why was my claim denied for TPL after I included an insurance denial as referred to in question #6?**

   Due to recent changes in interpretation of federal laws, Medicaid denies payment for any service that could have been paid for by a private plan had the recipient or provider complied with the private plan's requirements.

   Examples of common private plan noncompliance denials include

   - Failure to get an authorization referral from a PCP
   - Nonparticipating provider
   - Failure to obtain a second opinion
   - Failure to obtain prior approval

   In these circumstances, the provider may bill the recipient for these services, provided the noncompliance was not due to provider error, or the provider may appeal to the private plan.

   It may be the provider's responsibility to fulfill requirements of the private plans such as prior approval and referral authorization from the PCP.

8. **What are the uses of the Health Insurance Information Referral Form (DMA-2057) and where do I obtain copies?**

   Complete the DMA-2057 form in the following instances:

   - To delete insurance information (that is, the recipient no longer has third-party insurance, but the MID card indicates other insurance)
   - To add insurance information (that is, a recipient has third-party insurance that is not indicated on the MID card)
   - To change existing information (that is, a recipient never had the third-party coverage that is indicated on the MID card)

   A copy of the form is available in **Appendix G-22** or on DMA's Web site at http://www.ncdhhs.gov/dma/forms.html.

9. **If the Medicaid recipient's private health insurance company pays the recipient directly, what may I bill the recipient?**

   If the amount of the insurance payment is known, you may bill the recipient for that amount only. You may also file your claim to Medicaid indicating the third-party payment amount in the appropriate block on your claim form, and Medicaid will pay the Medicaid-allowable amount, less the insurance payment. If the insurance payment is unknown, you may bill the patient the total charges until the payment amount is known.

10. **May I have an office policy that states I will not accept Medicaid in conjunction with a private insurance policy?**

    Yes. A provider can refuse to accept Medicaid for recipients who also have third-party coverage, even though they accept Medicaid for recipients who do not have third-party coverage. However, providers must advise the recipient of the responsibility for payment before the services are rendered. The provider must obtain proper consent from the recipient for this arrangement.

11. What do I do when a recipient or another authorized person requests a copy of a bill that I submitted to Medicaid?

Regardless of whether you have received payment, if you have already submitted the claim to Medicaid, and if you have the proper patient authorization, you may provide a copy of the bill to the recipient, an insurance company, an attorney, or other authorized person. However, you can do so *only* if you comply with the following requirement. All copies of any bill that has been submitted to Medicaid *must* state "MEDICAID RECIPIENT, BENEFITS ASSIGNED" in large, bold print on the bill. If you provide a copy of a bill that was filed with Medicaid without this language, Medicaid may recoup this payment.

12. How do I determine the amount of refund due to Medicaid when Medicaid pays my claim and I subsequently receive payment from a third-party insurance carrier?

Once you have filed a claim with Medicaid and have received payment, your claim has been paid in full. Upon receipt of payment from the TPL carrier, you must refund to Medicaid the amount of Medicaid's payment and you must also refund to the patient or the liability carrier any remaining amount. By billing Medicaid and receiving payment, the provider relinquishes any right to Medicaid's payment for that service through assignment and subrogation. This includes the prohibition on the provider's billing for or receiving a recovery for the difference between the amount Medicaid paid and the provider's full charges. This practice violates both state and federal laws.

The provider has the option to defer billing Medicaid and instead pursue a claim for full charges with the liability carrier. As long as the provider has filed a claim with the liability carrier within one year from the date of service, and is diligently pursuing reimbursement from that liability carrier, the provider may file a claim with Medicaid within 180 days of a denial or payment from that carrier, even though the 180 days may end after the usual 12-month time limit for filing with Medicaid.

13. When do I file my claim with EDS and when do I file it with the TPR section?

Send your claim directly to EDS when

- The recipient has no private health insurance
- The insurance EOB reflects an insurance payment
- There is an insurance denial with the following reasons:
    - Applied to the deductible
    - Benefits exhausted
    - Noncovered services (meaning the service was not and will never be covered under this policy)
    - Pre-existing condition
    - Medicare/Medicaid dually eligible with no private health insurance

File your claim with the TPR section if the claim includes either a Health Insurance Information Referral Form (DMA-2057) or an insurance EOB indicating any other type of denial not mentioned in the question above.

14. If the Medicaid recipient is required by their private insurance to pay a co-payment amount, can this amount be collected up front at the time the services are rendered?

No. The provider cannot bill the Medicaid recipient for the co-payment amount unless the Medicaid payment is denied because the service was a non-covered service, and then only if the provider has advised the recipient in advance that the services are not covered.

Health Insurance Premium Payments

Payment of Health Insurance Premiums

The Health Insurance Premium Payment (HIPP) program is a cost-effective premium payment program for Medicaid recipients with catastrophic illnesses such as end-stage renal disease, chronic heart problems, congenital birth defects, cancer, and AIDS. These recipients are often at risk of losing private health insurance coverage due to nonpayment of premiums. DMA will consider the benefit of paying health insurance premiums for Medicaid recipients when the cost of the premium, deductible, and co-insurance is less than the anticipated Medicaid expenditure.

Eligibility Determination

To be eligible for Medicaid payment of premiums, the recipient must be authorized for Medicaid and have access to private health insurance (in most cases through an employer). DMA will pay the premiums only on existing policies or those known to be available to the recipient (for example, through COBRA). Premiums are paid for a family coverage policy only when the policy is cost effective and it is the only way the recipient can be covered. Family members who are not eligible for Medicaid cannot receive Medicaid payment for deductible, co-insurance, or cost-sharing obligations.

Eligibility Process

Medicaid reviews the case of each recipient who meets any of the conditions cited above for possible premium payment. DMA verifies the insurance information, obtains premium amounts, makes the cost-effectiveness determination, and notifies the recipient and the appropriate referral source.

When DMA determines that a group health insurance plan available to the recipient through an employer is cost effective, and the recipient is approved for participation in the HIPP program, the recipient is required to participate in the health insurance plan as a condition of Medicaid eligibility. If the recipient voluntarily drops the insurance coverage or fails to provide the information necessary to determine cost effectiveness, Medicaid eligibility may be terminated. The recipient is not required to enroll in a plan that is not a group health insurance plan through an employer. However, if it is determined that a non–group health plan is cost effective, DMA will pay the cost of the premium, co-insurance, and deductible of such a plan if the recipient chooses to participate.

Where to Obtain Information

Information about HIPP and the HIPP Application (DMA-2069) are available through the local county DSS office. Brochures and applicable forms are also available in the local health departments, hospitals, hospices, RHCs, and FQHCs. A copy of the HIPP Application (DMA-2069) is also available in **Appendix G-24** or on DMA's Web site at http://www.ncdhhs.gov/dma/forms.html.

Medicaid Credit Balance Reporting

Providers are required to submit a quarterly Medicaid Credit Balance Report **(Appendix G-25, -26)** reporting all outstanding Medicaid credit balances reflected in the accounting records as of the last day of each calendar quarter.

The report is used to monitor and recover "credit balances" due to Medicaid. A credit balance is defined as an improper or excess payment made to a provider as the result of recipient billing or claims processing errors. Credit balances include all money that is due to Medicaid, regardless of its classification in a provider's accounting records.

For example, if a provider maintains a credit balance account for a stipulated period (such as 90 days) and then transfers the account or writes it off to a holding account, this does not relieve the provider of its liability to Medicaid. In these instances, the provider is responsible for identifying and repaying all of the money due to Medicaid.

Completing and Submitting the Medicaid Credit Balance Report

The Medicaid Credit Balance Report requires specific information for each credit balance on a claim-by-claim basis. The form provides space for 15 claims, but it may be reproduced as many times as necessary to report all the required credit balances. Specific instructions for completing the report are on the reverse side of the form.

Send the report to the TPR section at the address listed on the form no later than 30 days following the end of the calendar quarter. (Calendar quarters end March 31, June 30, September 30, and December 31). **A report is required from hospital providers and long-term-care facilities even if a zero ($0.00) credit balance exists.**

Failure to submit a Medicaid Credit Balance Report in a timely manner could result in withholding of Medicaid payments until the report is received.

Only the completed form should be sent to the TPR section. Refund or recoupment requests should be sent to EDS along with all the necessary documentation to process the refund or recoupment. **Do not** send refunds or recoupment requests to the TPR section.